STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING _____ B. WING _____	C 06/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES - PIKE CREEK	5651 LIMESTONE ROAD WILMINGTON, DE 19808

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F000	INITIAL COMMENTS An unannounced complaint investigation survey was conducted at this facility June 6, 2017 through June 14, 2017. The facility census the first day of the survey was 177. The survey sample totaled six residents. In addition, one sub-sampled resident was added for observation. Abbreviations/definitions used in this report are as follows: NHA-Nursing Home Administrator; DON-Director of Nursing; QAC-Quality Assurance Coordinator; MD-Medical Doctor; NP-Nurse Practitioner; RN-Registered Nurse; PA-Physician Assistant; LPN-Licensed Practical Nurse; CNA-Certified Nurse's Aide; UM-Unit Manager; MAR-Medication Administration Record; Alzheimer's Disease-degenerative disorder that attacks the brain's nerve cells resulting in loss of memory, thinking and language; Cognitive-thinking, memory, reasoning; Severe Cognitive Impairment - unable to make own decisions; Vital Signs (VS)-clinical measurements, specifically pulse rate, temperature, respiration rate, and blood pressure, that indicate the state of a patient's essential body functions. Blood Pressure (BP)-the pressure of the blood in the circulatory system, often measured for diagnosis since it is closely related to the force and rate of the heartbeat and the diameter and elasticity of the arterial walls; Pulse (P)-a rhythmical throbbing of the arteries	F000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Electronically Signed	07/09/2017

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F000	Continued From page 1 as blood is propelled through them, typically as felt in the wrists or neck; Apical pulse- is taken when the patient is lying or sitting. A stethoscope is used to listen to the heart and placed at the 5th intercostal space (between ribs on left side of body); Respiratory rate (RR or R)-respiratory rate is the number of breaths an individuals takes per minute. The normal respiration rate for an adult at rest is 12 to 20 breaths per minute. A respiration rate under 12 or over 25 breaths per minute while resting is considered abnormal; Temperature (T)-the degree of internal heat of a person's body. The average normal body temperature is an oral temperature (by mouth) of 98.6 F; Fahrenheit (F)-a temperature scale; Fracture-broken bone; S/S-signs and symptoms; Evencare-brand name; Evencare glucometer-a medical device for determining the approximate concentration of glucose in the blood; Glucose-the simple sugar that is the chief source of energy for the body; x-ray-type of imaging that creates pictures of the inside of your body; ER-emergency room; ROM-the full movement potential of a joint; Tylenol-brand name for acetaminophen, a medication to treat pain or reduce fever; Tramadol-medication to treat moderate to severe pain; MDS-Minimum Data Set (standardized assessment forms) assessment utilized in nursing homes; Progress note - clinical documentation of care and services provided to the resident by the nurse/medical staff; PRN-as needed.	F000		

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F157 F157 SS=D	Continued From page 2 483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the residents physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the residents physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in 483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in 483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in 483.10(e)(6); or	F157 F157	It is the practice of the facility to immediately inform the resident; consult with the residents physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the residents physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in 483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in 483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in 483.10(e)(6); or	7/7/17 12:

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F157	Continued From page 3 (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews, and review of other facility documentation, it was determined that the facility failed to consult with the attending physician, for one (R2) out of six residents in the sample. R2 had a new onset of acute pain of the left thigh and a change in mobility and the facility failed to consult the attending physician. Findings include: The facility's guideline, titled Clinical Evaluation Focus documented that the licensed nurse's evaluation of a patient's condition after a fall, identification of changes in condition and recognition of emergent situations is critical to achieving positive patient outcomes. The licensed nurse is responsible for completing this evaluation and reporting changes in condition to the attending physician whenever any symptom, sign or apparent discomfort is sudden in onset, a marked change in relation to usual symptoms or unrelieved by initial interventions. Cross refer F309. The following was reviewed in R2's clinical record: 8/17/16 - Admission to the facility with diagnoses including Alzheimer's Disease.	F157	(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). 1. The R2 no longer resides in the facility. 2.The Director of Nursing and or designee will do random audits: -of the residents nurses notes to evaluate that when a resident has a new onset of acute pain and or change in mobilty that the attending physician is consulted. - of nursing documentation Post fall to validate the proper evaluation was completed and documented and if change in condition the physican was notified. 3. The Staff Developement Coordinator and or designee will inservice and re-educate the Nursing staff on : Consulting a physician when when new onset of acute pain and or change in mobility Also if you are not able to do a comprehensive assessment on a resident that has a new onset of acute pain and or change in mobility consult the physician Post fall nurses are documenting and evaulating the resident and if change in condition notify the physician 4. The Director of Nursing and or designee	

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F157	Continued From page 4 12/28/16 - Quarterly MDS Assessment documented R2 was severely cognitive impaired, walked in room and unit with supervision by staff. In addition, R2 did not receive any scheduled or PRN pain medication and R2 did not have any sign of pain or any documentation of pain within the last 5 days. 3/14/17 and timed 9:49 PM - A telephone verbal order by prescriber, E10 (MD) for x-ray of the hip, two views to rule out a fracture. 3/14/ 17 and timed 9:52 PM - Progress Note, by E5 (LPN), documented R2 was very tearful and holding on to her left hip sitting in the dining room and R2 was ambulating on the unit without any difficulties earlier this shift. R2 was assessed by E4 (RN supervisor) and E9 (NP) was made aware and ordered an x-ray of the left hip to rule out a fracture. 6/8/17 at approximately 3:00 PM, an interview with E4 [RN Supervisor] in the presence of E2 (DON) was held. E4 verbalized that she was notified by E5 that R2 was crying and rubbing her left leg. E4 verbalized that she attempted to complete a comprehensive physical assessment while R2 was sitting in the dining room chair before dinner, approximately 4:30 PM to 5:00 PM, however, R2 resisted and E4 was unable to complete the assessment. E4 reported that R2 attempted to take a couple of steps but quickly sat down on the chair and became tearful. E4 related that she instructed E5 to administer Tylenol and monitor R2's condition. E4 indicated that she had left early during that shift before 8:00 PM and she did not have any further contact with R2 on 3/14/17. E4 related that she did not consult with R2's attending physician. 6/8/17 at approximately 3:15 PM, an interview	F157	will audit nursing documentation to validate notification of physician when a resident has acute pain and or change in mobilitity and audit that a comprehensive assessment was completed. Post fall nurses documentation is evaulating the resident and if a change in condition the physican was notified These audits will be conducted daily times 5 days, then weekly times 2 weeks, then if appropriate monthly times 2 months. Cross refer to F309 The results of these audits will be forwarded to the Quality Assurance and Assessment Committee for review and action as appropriate. The Committee will determine need for further audits and/or action.	

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F157	Continued From page 5 with E5, with the presence of E2 was held. E5 verbalized that she was notified by E7 (CNA) that R2 was crying after dinner at approximately 6:00 PM. E5 observed R2 crying and rubbing her left thigh. E5 verbalized that she had contacted E4 and E4 had assessed R2 soon thereafter. E5 reported that R2 had stopped crying at some point and when R2 was put into bed around 9:00 PM, R2 started to cry again and E5 proceeded and contacted E4 and E5 recalled a reassessment of R2 was completed by E4. In addition, E9 (NP) was contacted due to the resident moaning in bed and an order for x-ray of hip was obtained. 6/14/17 at approximately 1:00 PM, a telephone interview with E12 (PA) was conducted. E12 verbalized that she was familiar with R2 and that R2 was independent with ambulation in the unit. E12 did not recall when she assessed R2 on the morning of 3/15/17, however, did order Tramadol for pain due to the left thigh pain. E12 verbalized that she was made aware of the x-ray results soon after the assessment of R2 and an order was communicated to send the resident to the hospital for treatment. E12 verbalized if a comprehensive clinical assessment could not be performed on the evening of 3/14/17 by a RN, and R2 had a change in mobility, R2's attending physician should have been contacted. 6/14/17 at approximately 1:50 PM, a telephone interview with E9 was conducted. E9 verbalized that she is not familiar with R2 and does not recall the specifics of the information that she was provided the evening of 3/14/17 by E5, however, if a resident is experiencing a new onset of pain, in the thigh area, her standard would be to order an x-ray to rule out a fracture. 6/14/17 and at approximately 2:20 PM, an	F157		

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F157	Continued From page 6 Interview with E2 was held. E2 verbalized a comprehensive clinical assessment of pain in the thigh area would include range of motion, rotation, length of leg. When E4 was unable to complete this assessment on 3/14/17 due to R2's refusal and E4 observed change in R2's ability to bear weight and had to quickly sit down after taking a couple of steps, E2 would have expected that R2's attending physician be consulted. Findings reviewed on 6/14/17 at approximately 4:00 PM with E1 (NHA), E2, E3 (QAC), and E14 (ICP).	F157		
F225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of	F225	It is the practice of the facility to : (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness	7/20/17

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F225	Continued From page 7 actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F225	for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	

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F225	Continued From page 8 Based on record review, staff interviews, and review of other facility documentation as indicated, it was determined that the facility failed to thoroughly investigate an injury of unknown origin which had a potential for an allegation of neglect for one (R2) out of six sampled residents. In addition, the facility failed to thoroughly investigate an allegation of abuse for one (R4) out of six sampled residents. Findings include: The surveyor was provided the following two documentation by the facility, in reference to the facility's investigative process: - The facility's policy entitled Patient Protection Abuse, Neglect, Exploitation, Mistreatment and Misappropriation Prevention Indication for the investigation, it included seven steps: - Problem identification; Report; Establish Facts; Verify and Investigate; Evaluate and Expand' Next Steps; Track and Document. - Conducting Investigations-Skilled Nursing Facilities. "3. Plan Investigation...Who will be interviewed?" Review of these documentation lacked guidance regarding who should be interviewed, during the investigation. 1. Review of the investigation and the facility's records for R2 revealed: 3/15/17 and timed 2:00 PM - Incident Report and Investigation, documented that the incident date and time was 3/15/17 at 2:00 PM, with the description of the incident as a fracture with the location of the incident was unknown . The	F225	1. 1.R2 no longer resides in the facility 2.The Director of Nursing and or designee will conduct random audits of reportables and incidents in last 30 days to evaluate the facility did conduct a thorough investigation including parties involved in the incident are interviewed and witness statement obtained. 3. The Quality Assurance Consultant will re-educate the Interdisciplinary team on the "8 steps of conductin an effective investigation. (attached) The Staff Development Coordinator and or Designee will inservice the licensed nursing staff on obtaining witness statements of parites involed in the incident. 4. The Director of Nursing and or designee will conduct random audits of reportables and incident reports in the last 30 days to evaluate the facility did a thorough investigation. The Director of Nursing and or designee will audit new reportables of Abuse and neglect to evaluate it has had a thorough investigation and parties involved have been interviewed and witness statements obtained prior to the 5 day follow up being submitted to the state. These audits will be conducted daily x5, than weekly x2, than if appropriate monthly times 2 months. The results of these audits will be	

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F225	Continued From page 9 narrative documented that R2 complained of new onset of left hip pain during the 3:00 to 11:00 PM shift on 3/14/17, RN assessed and called MD. Left x-ray ordered and results showed fracture of the left hip. NP was notified and order to send to ER. The investigation was completed by E13 (RN, UM) on 3/18/17 and signed by E1 (NHA) and E2 (DON) on 4/10/17. The investigation was unable to determine the cause of the fracture and documented that R2 had no falls or incident on 3/14/17. This investigation lacked evidence that the facility interviewed E6 (CNA), who was assigned to R2 during the 3:00 PM to 11:00 PM on 3/14/17. 6/13/17 at approximately 12:10 PM, an interview with E6 was conducted in the presence of E2. E6 confirmed that she was the assigned CNA for R2 during the 3:00 PM - 11:00 PM shift on 3/14/17. E6 recalled that R2 was in a wheelchair at the beginning of the shift and at approximately 3:50 PM, when E6 took R2 to the toilet, when R2 stood up, so that the adult brief could be removed, R2 had pain and E6 informed E5 [LPN]. Sometime after 8:00 PM, R2 was found sitting on the floor in the dining room in the secured unit and E6 informed E5. E6 and E7 [CNA] was instructed to pick up the resident from the floor, place the resident in the wheelchair and place R2 in the bed. 6/14/17 at approximately 10:00 AM, the surveyor was informed by E1 [NHA], that a new investigation has been initiated due to E6 verbalization that R2 was found on the floor on 3/14/17. As this was new information for the facility and the facility did not interview E6 while conducting their investigation previously. The above facility's documentation failed to include all parties who needed to be interviewed surrounding this incident involving an injury of	F225	forwarded to the Quality Assurance and Assessment Committee for review and action as appropriate. The Committee will determine need for further audits and/or action. 2. 1. R4 does reside in the facility and is free of abuse and neglect 2.The Director of Nursing and or designee will conduct random audits in last 30 days to evaluate the facility did conduct a thorough investigation including parties involved in the incident are interviewed and that any allegation of abuse and neglect are thoroughly investigated. 3. The Quality Assurance Consultant will re-educate the Interdisciplinary team on the "8 steps of conducting an effective investigation. (attached) The Staff Develop Coordinator and or Designee will inservice the licensed nursing staff on obtaining witness statements of parties involved in the incident and to thoroughly investigate any allegations of abuse and neglect. 4. The Director of Nursing and or designee will conduct random audits of reportables and incident reports in the last 30 days to evaluate the facility did a thorough investigation. The Director of Nursing and or designee will audit new reportables of Abuse and neglect to evaluate it has had a thorough investigation and parties involved have been interviewed prior to the 5 day follow up being submitted to the state. These audits will be conducted 5 times	

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F225	Continued From page 10 unknown origin. Findings reviewed on 6/14/17 at approximately 4:00 PM with E1, E2, E3 (QAC), and E14 (ICP). 2. Review of the investigation and the facility's records for R4 revealed: 3/30/17 through 4/1/17 - Incident Report documented that the incident of an allegation of physical abuse occurred on 3/29/17 between 8:00 PM and 9:00 PM, in which R4's son reported observing E7 (CNA) pushing R4's hand against the wall, in the bathroom, to turn R4 around while providing incontinence care and R4 was resisting. Review E7's statement indicated that E7 called for E15 [CNA] to come help him. Before E15 came, since R4 was cooperative, E7 proceeded with incontinence care without E15. The facility's conclusion documented that the facility was unable to substantiate the allegation of abuse. 6/6/17 at approximately 12:20 PM, an interview with E2 [DON] was held. E2 verbalized that she had placed a telephone call to E15 in an attempt to obtain a witness interview, however, E15 did not return the call, thus, E15 was not interviewed. E2 did confirm that E15 worked at the facility on 3/30/17, 3/31/17, and 4/1/17 while the investigation was being conducted but was not interviewed as a witness. Findings reviewed on 6/14/17 at approximately 4:00 PM with E1, E2, E3, and E14.	F225	weekly times 1, then 2 times weekly times 2 than if appropriate monthly times 2 months. The results of these audit will be forwarded to the Quality Assurance and Assessment Committee for review and action as appropriate. The Committee will determine need for further audits and/or action.	
F309 SS=G	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life	F309	It is the practice of the facility that Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must	7/20/17

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	085033	A. BUILDING _____ B. WING _____	C 06/14/2017

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F309	Continued From page 11 Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the residents comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and review of other facility documentation as indicated, it was determined that for one (R2) of	F309	receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the residents comprehensive assessment and plan of care. Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents goals and preferences. 1. R2 no longer resides in the facility. 2.The Director of Nursing and or designee will do random audits of the residents nurses notes to evaluate that when a resident has a new onset of acute pain and	

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F309	Continued From page 12 six sampled residents, the facility failed to provide the necessary care and services for the resident to attain her highest level of physical and mental well-being. R2 experienced a new onset of acute pain of the left thigh and a change in mobility status from independent ambulation to requiring a wheelchair. The facility failed to conduct a comprehensive clinical assessment, including pain assessment. The facility failed to notify the physician about the new onset of acute pain and change in R2's mobility status. Although R2 was displaying negative vocalization of pain, as evidenced by crying and moaning, the facility failed to provide pain medication for approximately 11 hours after the first identification of pain. An x-ray later showed R2 had a broken hip. There is inconsistent documentation in the clinical record between the right and left hip and consequently in this report. Additionally interviews with E5 (LPN) and E4 (RN) recorded below demonstrate a lack of documentation regarding the events that occurred on 3/14/17 which inhibited an accurate investigation of the trauma sustained by R2. Findings include: The pain management standards, approved by the American Geriatrics Society in April 2002, included: appropriate assessment and management of pain; assessment in a way that facilitates regular reassessment and follow-up; same quantitative pain assessment scales should be used for initial and follow up assessment; set standards for monitoring and intervention; and collect data to monitor the effectiveness and appropriateness of pain management. Review of facility policy entitled "Pain Practice Guide", issued on November 2011 included: - The PAINAD Scale is used for patients who	F309	or change in mobilty that the attending physician is consulted. Review nursing documentation Post fall to validate the proper evaluation was completed and documnetation and if change in condition the physican was notified. - The Director of Nursing and or designee will do random audits of residents charts to ensure that the clinical record is complete and accurate. - The Director of Nursing and or designee will do random audits of residents progress notes to evaluate the nurses are documenting accurately with the assessement stating the time it occured. - The Director of nursing and or designee will do random audits of residents progress notes to evaluate the nurses are documenting that pain medication is being administered timely. 3. The Staff Developement Coordinator and or designee will inservice and re-educate the Nursing staff on : Consulting a physician when new onset of acute pain and or change in mobility. Also if you are not able to do a comprehensive assessment on a resident that has a new onset of acute pain and or change in mobility consult the physician. Post fall nurses are to document and evaluate the resident and if change in condition notify the physician - The staff Development Coordinator and	

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F309	Continued From page 13 cannot communicate (verbal, written, gesture) about their pain. The observations are converted to numeric score with "0" being absence of pain and "10" as being the worst pain. This may include patients who are unable to complete the pain interview..., have cognitive impairment or cannot verbally communicate. The non-specific signs and symptoms that may suggest the presence of pain include vocal (crying, moaning, groaning), rubbing (body guarding), resisting movement or care, change in gait, loss of function. - Obtain pain scale scores daily and before and after administration of PRN pain medication. Review of R2's clinical record revealed: 8/17/16 - Admission to the facility with diagnoses including Alzheimer's Disease. 8/17/16 - Physicians' orders included PRN Tylenol every 4 hours PRN for pain. 12/28/16 - Quarterly MDS Assessment documented R2 was severely cognitively impaired, walked in room and unit with supervision by staff. In addition, R2 did not receive any scheduled or PRN pain medication and R2 did not have any sign of pain or any documentation of pain within the last 5 days. 1/23/17 - Care plan problem for pain related to arthritis left hand 4th and 5th digit, had the goal that R2 will express that pain management is within acceptable limits. Interventions included to report nonverbal expressions of pain such as moaning, striking out, grimacing, crying, thrashing, change in breathing. 3/1/17 through 3/13/17 - Progress Notes had no documented behavior of crying or moaning.	F309	or designee will inservice the nursing staff on completing and documenting an acurate comprehensive assessments on residents who have new on set of acute pain. Inservice the nursing staff on facility pain management guidelines to include medicating the resident timely, to assess the resident using the pain management guidelines, to medicate resident timely if needed base on the pain assessment and to re-assess after the pain mediation is given using the pain assessment guidelines to assure medication effective. - The Staff Development Coordinator and or designee will inservice the nursing staff on accurate documentation, complete assessments and stating the time of the assessment in their notes and what occurred. 4. The Director of Nursing and or designee will audit nursing documentation to validate notification of physician when a resident has acute pain and or change in mobilitly and audit that a comprehensive assessment was completed. These audits will be conducted daily times 5 days, then weekly times 2 weeks, then if appropriate monthly times 2 months. - The Director of Nursing and or designee will conduct audits in the Eagle room of nursing progress notes to evaluate the nurses are completing comprehensive assesments of residents with new onset of acute pain and that pain medication is given timely to the resident. Post fall, nurses are documenting and evaulating the resident and if change in condition the	

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F309	Continued From page 14 3/14/17 and timed 3:56 PM - The Pain Level Summary documented that R2 had a pain scale of "0" indicating no pain. However CNA [E6] statement noted R2 expressed pain at 3:50 PM during toileting. No further assessment of R2's new onset of pain was noted. 3/14/17 and timed 9:49 PM - A telephone verbal order by prescriber, E10 (MD) for x-ray of the hip, two views to rule out a fracture. 3/14/ 17 and timed 9:52 PM - Progress Note, by E5 (LPN), documented R2 was very tearful and holding on to her left hip sitting in the dining room [exact time not documented] and R2 was ambulating on the unit without any difficulties earlier this shift. R2 was assessed by E4 (RN supervisor) and E9 (NP) was made aware and ordered an x-ray of the left hip to rule out a fracture. Although this progress note documented that R2 was assessed by E4, record review lacked evidence of a comprehensive assessment of the new acute pain. 3/14/17 - 3:00 PM to 11:00 PM shift, Medication Administration Record (MAR) lacked evidence of any administration of PRN Tylenol for pain. 3/15/17 and timed 3:27 AM - Progress Note, by E8 (LPN), 11:00 PM - 7:00 AM shift, documented continues to monitor VS and right hip pain. R2 continues with signs and symptoms of pain when her legs are moved and x-ray to be done in the AM. PRN Tylenol given for pain pending results. Denies pain at this time. (An interview [6/19/17 at 10:30 AM] with E8 confirmed this documentation was accurate, in reference to the right hip pain, despite other documentation of left hip pain).	F309	physican was notified These audits will be conducted daily times 5 days, then weekly times 2 weeks and then if appropriate monthly times 2 months. - The Director of Nuring and or designee will audit nursing progress notes in the Eagle room meeting to evaluate the nurses are documenting the time of which incident occured. These audits will be conducted daily x5, then weekly times 2, then if appropriate monthly time 2 months. The results of these audits will be forwarded to the Quality Assurance and Assessment Committee for review and action as appropriate. The Committee will determine need for further audits and/or action	

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F309	Continued From page 15 3/15/17 and timed 3:30 AM - The Pain Level Summary documented that R2 had a pain scale of "5" indicating moderate level of pain. 3/15/17 and timed 3:30 AM - Progress Note, by E8 documented Tylenol given for complaint of right hip pain with a pain score of 5 out of 10. (An interview with E8 confirmed this documentation was accurate, in reference to the right hip pain). 3/15/17 - MAR documented at 3:30 AM, Tylenol as administered due to complaints of pain in hip. 3/15/17 - 11:00 PM - 7:00 AM shift, MAR documented "E" indicating effective. Although the post pain assessment indicated effective, the facility failed to utilize the same pain scale [0 to 10 scale] for reassessment of the intervention, rather than the numeric scale as required by facility policy. 3/15/17 and timed 5:09 AM - Progress Note, by E8 documented that the pain medication was effective with R2 with no S/S of pain, able to move her legs without moaning. Although the post pain assessment indicated effective, the facility failed to utilize the same scale for post pain assessment. 3/15/17 and timed 11:14 AM - Progress Note, by E11 (LPN), documented that R2 remains in bed and needs are met and awaiting x-ray to left hip. 3/15/17 and timed 12:03 PM - Progress Note, by E11, documented Tylenol administered at 12:03 PM for pain score of 4, indicating mild to moderate level of pain. 3/15/17 and timed 12:03 PM - The Pain Level	F309		

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F309	Continued From page 16 Summary documented that R2 had a pain scale of 4, indicating mild to moderate level of pain. 3/15/17 - 7:00 AM - 3:00 PM shift, MAR documented "U" indicating unknown, as to the effectiveness of the pain relief, from the Tylenol administered at 12:03 PM. 3/15/17 and timed 1:50 PM - Progress Note, by E11, documented x-ray results pending and R2 was seen by E12 (PA) and gave new orders for Tramadol PRN for moderate to severe pain. 3/15/17 and timed 1:51 PM - Progress Note, by E11, documented R2 remains in bed until results of x-ray return. R2 given meals in bed. R2 medicated as ordered for pain (Tylenol at 12:03 PM). No bruising noted to left hip, R2 complain of pain when turning in bed. 3/15/17 and timed 2:28 PM - Progress Note, by E11, documented results of left hip x-ray given to NP and NP ordered to send to ER for evaluation and 911 called. 3/15/17 and untimed Progress Note, by E12 (PA), documented that E12 was asked, by nursing to see patient who is having difficulty with ambulation and holding left thigh secondary to pain. There is no documented witnessed fall. VS BP 119/65, P 100, R 18, T97.6 F. Upon exam, noted decrease ROM of left hip with tenderness of hip and thigh. Plan included x-ray, Tramadol PRN every 6 hours. On the back of this progress note, documented the results of the x-ray, as a fracture with moderate displacement [out of alignment] and plan was to send R2 to the emergency room. 3/15/17 - Fire company pre-hospital care report documented that the 911 call was received at 2:	F309		

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F309	Continued From page 17 33 PM and R2 arrived at the hospital at 3:14 PM. 6/8/17 at approximately 3:00 PM, an interview with E4 [RN Supervisor] in the presence of E2 (DON) was held. E4 verbalized that she was notified by E5 [LPN] that R2 was crying and rubbing her left leg. E4 verbalized that she attempted to complete a comprehensive physical assessment while R2 was sitting in the dining room chair before dinner, approximately 4:30 PM to 5:00 PM, however, R2 resisted and E4 was unable to complete the assessment. E4 reported that R2 attempted to take a couple of steps but quickly sat down on the chair and became tearful. E4 related that she instructed E5 to administer Tylenol and monitor R2's condition. E4 indicated that she had left early during that shift before 8:00 PM and she did not have any further contact with R2 on 3/14/17. E4 related that she did not notify R2's attending physician. 6/8/17 at approximately 3:15 PM, an interview with E5, in the presence of E2 was held. E5 verbalized that she was notified by E7 (CNA) that R2 was crying after dinner at approximately 6:00 PM. E5 observed R2 crying and rubbing her left thigh. E5 verbalized that she had contacted E4 and E4 had assessed R2 soon thereafter. E5 reported that R2 had stopped crying at some point and when R2 was put into bed around 9:00 PM, R2 started to cry again. E5 proceeded and contacted E4 [RN Supervisor] and E5 recalled a reassessment of R2 was completed by E4. In addition, E9 [NP] was contacted due to the resident moaning in bed. 6/8/17 at approximately 3:55 PM, an interview with E7 [CNA], in the presence of E2 was held. E7 verbalized that he was not the assigned CNA	F309		

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F309	Continued From page 18 for R2 during the 3:00 PM - 11:00 PM shift but rather E6 (CNA) was the assigned CNA. E7 did confirm that E7 informed E5 that R2 was crying, while sitting in the dining room chair before dinner on 3/14/17. In addition, E7 reported that he assisted E6 in turning and repositioning R2 in bed at approximately 8:00 PM since R2 was unable to do so and was crying during this activity. E7 verbalized that prior to this date, R2 was independent in turning and repositioning in bed. 6/13/17 at approximately 12:10 PM, an interview with E6 [CNA] was conducted in the presence of E2. E6 confirmed that she was the assigned CNA for R2 during the 3:00 PM - 11:00 PM shift on 3/14/17. E6 recalled that R2 was in a wheelchair at the beginning of the shift and at approximately 3:50 PM, when E6 took R2 to the toilet. When R2 stood up, so that the adult brief could be removed, R2 had pain and E6 informed E5 [LPN]. Sometime after 8:00 PM, R2 was found sitting on the floor in the dining room in the secured unit and E6 informed E5. E6 and E7 [CNA] were instructed to pick the resident up from the floor, place the resident in the wheelchair and place R2 in the bed. E6 verbalized that R2 was placed in bed and remembered that R2 was crying and hunched over to the right side of the bed. Again, E5 was made aware that R2 was experiencing pain and crying. E6 reported that she checked on R2 approximately two hours afterwards and no incontinence care was needed at that time. 6/13/17 at approximately 3:15 PM, a subsequent interview with E5 was conducted in the presence of E2 [DON]. E5 verbalized that it was her recollection that R2 had a behavior of crying, thus, it was E5's determination that crying was not a sign of R2 experiencing pain and PRN	F309		

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F309	Continued From page 19 Tylenol was not administered during her shift from 3:00 PM to 11:00 PM. E5 denied that R2 was found on the floor after dinner on 3/15/17. 6/14/17 at approximately 1:00 PM, a telephone interview with E12 (PA) was conducted. E12 verbalized that she was familiar with R2 and that R2 was independent with ambulation in the unit. E12 did not recall when she assessed R2 on the morning of 3/15/17, however, did order Tramadol for pain due to the left thigh pain. E12 verbalized that she was made aware of the x-ray results soon after the assessment of R2 and an order was communicated to send the resident to the hospital for treatment. E12 verbalized if a comprehensive clinical assessment could not be performed on the evening of 3/14/17 by a RN, and R2 had a change in mobility, R2's attending physician should have been contacted. 6/14/17 at approximately 1:50 PM, a telephone interview with E9 [NP] was conducted. E9 verbalized that she is not familiar with R2 and does not recall the specifics of the information that she was provided with on the evening of 3/14/17. However, if a resident is experiencing a new onset of pain, in the thigh area, her standard would be to order an x-ray to rule out a fracture. 6/14/17 at approximately 2:20 PM, an interview with E2 [DON] was held. E2 verbalized a comprehensive clinical assessment of pain in the thigh area would include range of motion, rotation, length of leg. When E4 [RN Supervisor] was unable to complete this assessment on 3/14/17 due to R2's refusal and E4 observed change in R2's ability to bear weight and had to quickly sit down after taking couple of steps, E2 would have expected that R2's attending physician be notified. E2	F309		

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F309	Continued From page 20 confirmed that pharmacological intervention of Tylenol was not administered, as instructed by E4 and as ordered by R2's attending physician, during the 3:00 - 11:00 PM shift, when R2 was displaying signs and symptoms of pain, which included crying and moaning. Additionally, E2 confirmed no VS were completed during this shift. 6/19/17 approximately 10:30 AM, a telephone interview with E8 [LPN] revealed that his recollection was that R2 was experiencing pain in the right hip, as evidenced by moaning when her legs were moved while she was in bed during the 11:00 PM to 7:00 AM shift on 3/15/17. The facility failed to: -conduct a comprehensive clinical assessment, including pain assessment when R2 developed a new onset of acute left thigh pain in conjunction with a change in mobility status. -failed to provide pain medication for approximately 11 hours after the first identification of pain. Findings reviewed on 6/14/17 at approximately 4:00 PM with E1 (NHA), E2 [DON] , E3 (QAC), and E14 (ICP).	F309		
F441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all	F441	It isthe practice of the facility to: (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for	7/20/17

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	085033	A. BUILDING _____ B. WING _____	C 06/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES - PIKE CREEK	5651 LIMESTONE ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F441	Continued From page 21 residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to 483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed	F441	all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to 483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the	

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F441	Continued From page 22 by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility&IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of manufacturer information for the glucometer device, it was determined that the facility failed to ensure proper infection control techniques during glucometer use for one [SSR1] out of one residents observed. Findings include: Review of the Healthcare Professional Operator's Manual for Evercare G3 blood glucose monitoring system, indicated: Cleaning and disinfecting will be done between each patient and the approved product included Dispatch Hospital Cleaner Disinfectant with Bleach. During medication administration observation for SSR1 on 6/6/17 at approximately 12:05, E16 (RN) used the Evencare G3 glucometer to obtain blood from SSR1. After using the glucometer, E16 placed the glucometer back in the medication cart drawer without cleaning and disinfecting the device. An interview immediately after the above observation with	F441	disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility&IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.the practice of the facility 1. The gluccometer was disinfected immediately with dipatch wipes The nurse was given one on one education 2.The Director of Nursing and or designee will conduct audits of residents who require glucometer use to evaluate the glucometer machine is being cleaned immediately after use with a dispatch wipe. 3. The Staff Development Coordinator and or design will inservice the nurses on proper infection control procedure techniques during glucometer use for residents. The Staff Development and or designee will do random evalutions of nurses verbalizing and demostrating how to properly clease the gulcometer after use. 4. The Director of Nursing and or designee	

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F441	Continued From page 23 E16 confirmed that no cleaning and disinfecting of the device was completed prior to use. 6/6/17 at approximately 3:00 PM, an interview with E14 (ICP) confirmed that the glucometer must be cleaned and disinfected, by using Dispatch Hospital Cleaner Disinfectant with Bleach before using the device on a resident. Findings reviewed on 6/14/17 at approximately 4:00 PM with E1 (NHA), E2 (DON), E3 (QAC), and E14.	F441	will conduct audits of the residents who require glucometer use to evalute the nurse is following the infection control procedure using the dispatch wipes post resident use. This audit will be conducted daily times 5 days, than weekly 2 times, then if appropriate monthly time 2 months. The results of these audits will be forwarded to the Quality Assurance and Assessment Committee for review and action as appropriate. The Committee will determine need for further audits and/or action	
F514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided;	F514	It is the facilities practice in accordance with accepted professional standards and practices,to maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must conta (I) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations	8/20/17

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F514	Continued From page 24 (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physicians nurses and other licensed professionals progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under 483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined that the facility failed to ensure that the clinical record for one (R2) out of six sampled residents was complete and/or accurate. Findings include: 1a. Cross refer F309. The following was reviewed in R2's clinical record: 3/14/ 17 and timed 9:52 PM - Progress Note, by E5 (LPN), documented R2 was very tearful and holding on to her left hip sitting in the dining room and R2 was ambulating on the unit without any difficulties earlier this shift. R2 was assessed by E4 (RN supervisor) and E9 (NP) was made aware and ordered an x-ray of the left hip to rule out a fracture. Although this progress note documented that R2 was assessed by E4, record review lacked evidence of a comprehensive assessment of the new acute pain. 6/8/17 at approximately 3:00 PM, an interview with E4 was conducted, in the presence of E2 (DON). E4 verbalized that she was notified by E5 that R2 was crying and rubbing her left leg. E4 verbalized that she attempted to complete a	F514	and determinations conducted by the State; (v) Physicians nurses and other licensed professionals progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under 483.50 1.a cross refer F309 1. R2 no longer resides in the facility 2.The Director of Nursing and or designee will do random audits of residents' charts to ensure that the clinical record is complete and accurate. 3. The Staff Developement Coordinator and or designee will inservice the nursing staff on completing and documenting an accurate comprehensive assessment on residents who have new on set of acute pain. 4. The Director of Nursing and or designee will conduct audits in the Eagle room of nursing progress notes to evaluate the nurses are doing comprehensive assesments of residents with new on set of acute pain. these audits will be conducted daily times 5 days, then weekly times 2 weeks and then if appropriate monthly times 2 months. The results of these audits will be forwarded to the Quality Assurance and Assessment Committee for review and action as appropriate. The Committee will	

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F514	Continued From page 25 comprehensive physical assessment while R2 was sitting in the dining room chair before dinner, approximately 4:30 PM to 5:00 PM, however, R2 resisted and E4 was unable to complete the assessment. E4 reported that R2 attempted to take a couple of steps but quickly sat down on the chair and became tearful. E4 related that she instructed E5 to administer Tylenol and monitor R2's condition. E4 confirmed that lack of documentation, related to the completed assessment as well as instructions to administer Tylenol and to monitor R2's condition. Findings reviewed on 6/14/17 at approximately 4:00 PM with E1 (NHA), E2, E3 (QAC), and E14 (ICP). 1b. Cross refer F309. 3/14/ 17 and timed 9:52 PM - Progress Note, by E5 [LPN], documented R2 was very tearful and holding on to her left hip sitting in the dining room and R2 was ambulating on the unit without any difficulties earlier this shift. R2 was assessed by E4 [RN Supervisor] and E9 [NP] was made aware and ordered an x-ray of the left hip to rule out a fracture. Although E5 documented that R2 was very tearful and holding on to her left hip, the documentation lacked evidence of the examination time in which this had occurred. 6/8/17 at approximately 3:15 PM, an interview with E5, in the presence of E2 was held. E5 verbalized that she was notified by E7 (CNA) that R2 was crying after dinner at approximately 6:00 PM. E5 observed R2 crying and rubbing her left thigh. E5 verbalized that she had contacted E4 and E4 had assessed R2 soon thereafter. E5 reported that R2 had stopped	F514	determine need for further audits and/or action. 1.b cross refer F309 1. R2 no longer resides in the facility 2. The Director of Nurinig and or designee will do random audits of residents progress notes to evaluate the nurses are documenting accurately with the assessement stating the time it occurred. 3.The Staff Development Coordinator and or designee will inservice the nursing staff on accurate documentation, complete assessments and stating the time of the assessment in their notes and what occurred. 4. The Director of Nuring and or designee will audit nursing progress notes in the Eagle room meeting to evaluate the nurses are documenting the time the incident occurred. These audits will be conducted daily x5 days, the weekly times 2, then if appropriate monthly time 2 months. The results of these audits will be forwarded to the Quality Assurance and Assessment Committee for review and action as appropriate. The Committee will determine need for further audits and/or action. 2. 1. R2 no longer resides in the facility 2. The Director of Nursing and or designee will conduct random audits:	

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F514	Continued From page 26 crying at some point and when R2 was put into bed around 9:00 PM, R2 started to cry again. E5 proceeded and contacted E4 and E5 recalled a reassessment of R2 was completed by E4. E5 confirmed that the time of R2 crying after dinner was not documented in the above progress note as well as R2 crying again after R2 was put in the bed around 9:00 PM. Findings reviewed on 6/14/17 at approximately 4:00 PM with E1, E2, E3, and E14. 2. 3/15/17 and timed 2:00 PM - Incident Report and Investigation, documented that the incident date and time was 3/15/17 at 2:00 PM, with the description of the incident as a fracture with the location of the incident was unknown . The narrative documented that R2 complained of new onset of left hip pain during the 3:00 to 11:00 PM shift on 3/14/17, RN assessed and called MD. Left x-ray ordered and results showed fracture of the left hip. NP was notified and order to send to ER. The investigation was completed by E13 (RN, UM) on 3/18/17 and signed by E1 (NHA) and E2 (DON) on 4/10/17. The investigation was unable to determine the cause of the fracture and documented that R2 had no falls or incident on 3/14/17. This investigation lacked evidence that the facility interviewed E6 (CNA), who was assigned to R2 during the 3:00 PM to 11:00 PM on 3/14/17. 6/8/17 at approximately 3:00 PM, an interview with E4 [RN Supervisor] in the presence of E2 (DON) was held. E4 verbalized that she was notified by E5 [LPN] that R2 was crying and rubbing her left leg. E4 verbalized that she attempted to complete a comprehensive physical assessment while R2 was sitting in the dining room chair before dinner, approximately 4:30 PM to 5:00 PM, however, R2 resisted and	F514	-incident reports and or reportables to evaluate there is a thorough investigation of the event and parties involved are interviewed and have witness statments. - progress notes to evaluate the nurses have notified the physcian when a resident refuses to allow a comprehensive assessment to be completed and the notes reflect consistent and accurate documentaiton of the event 3. The Quality Assurance Consultant will re-educate the Interdisciplinary team on the "8" steps of conducting an effective investigation. (attached) The Staff Development Coordinator and or Designee will inservice the licensed nursing staff on obtaining witness statements of parites involved in the incident and to thoroughly investigate any allegations of abuse and neglect notifying physican and documenting so the note reflects the time of the event 4. The Director of Nursing and or designee will conduct audits of the nursing progress notes, incidents and or reportables to evaluate there is thorough investigation of the event and parties involved are interviewed and have witness statements. The nurses progress notes will be audited to evaluate the nurses have notified the physician when the resident refuses to allow a comprehensive assessment and the notes reflect consistent and accurate documentation. The results of these audits will be forwarded to the Quality Assurance and	

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F514	Continued From page 27 E4 was unable to complete the assessment. E4 reported that R2 attempted to take a couple of steps but quickly sat down on the chair and became tearful. E4 related that she did not notify R2's attending physician, when the comprehensive physical assessment could not be completed. 6/8/17 Although E4 confirmed that E4 did not notify R2's attending physician when she was unable to complete an assessment, the facility's incident report and investigation documentation incorrectly documented that the"... RN assessed and called MD..." Additionally, the incident report and investigation incorrectly documented that the "...NP was notified (of the x-ray results) and order send to ER" since the order was from the PA (E12). The facility failed to: -have consistent documentation regarding the exact location of the leg pain experienced by R2. -have sufficient, accurate documentation to ensure a thorough investigation of the actual events that occurred on 3/14/17 when R2 sustained a fracture. Findings reviewed on 6/14/17 at approximately 4:00 PM with E1, E2, E3, and E14.	F514	Assessment Committee for review and action as appropriate. The committee will determine need for further audits and/or action.	

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DELAWARE HEALTH
AND SOCIAL SERVICES
Division of Long Term Care
Residents Protection

3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: ManorCare Pike Creek

DATE SURVEY COMPLETED: June 14, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by references and also cites the findings specified in the Federal Report. An unannounced complaint investigation survey was conducted at this facility June 6, 2017 through June 14, 2017. The facility census the first day of the survey was 177. The survey sample totaled six residents. In addition, one sub-sampled resident for observation.		
3201	**Regulations for skilled and intermediate care facilities**		
3201.1	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross Refer Cross refer to the CMS 2567-L survey completed June 14, 2017: F0157, F0225, F0309, F0441, and F514.		

Provider's Signature _____ Title Administrator Date 8/29/17